Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PREFERRED IMAGING AT THE MEDICAL CENTER
5920 FOREST PARK ROAD
DALLAS TX 75235-6413

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-0302-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 06/29/11, we called and spoke with adjuster, Valerie Wilkerson to acquire information on compensable body parts and if service needs pre-authorization. She stated that the service is initial and does not require pre-authorization and also claim is non-network, therefore, no pre-authorization requirements. However, the insurance carrier has denied our claim due to no pre-authorization obtained. Our facility meet the requirements to be reimbursed for the service we rendered. Please settle this matter accordingly."

Amount in Dispute: $687.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2011	Cervical MRI – CPT code 72141	$687.92	$687.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective

March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. 28 Texas Administrative Code §134.600, requires preauthorized for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 19, 2011
   - 197-Percertification/authorization/notification absent.
   - 927-Utilization review decision.
   - 930-Pre-authorization required, reimbursement denied.

   Explanation of benefits dated August 4, 2011
   - 197-Percertification/authorization/notification absent.
   - 927-Utilization review decision.
   - 930-Pre-authorization required, reimbursement denied.
   - No allowance change.

Issues

1. Did the disputed cervical MRI require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed Cervical MRI based upon "197-Percertification/authorization/notification absent," and "930-Pre-authorization required, reimbursement denied."

   28 Texas Administrative Code §134.600(p)(8)(A) states "Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline."

   Review of the submitted documentation finds that the disputed MRI was the initial MRI; therefore, preauthorization was not required. The insurance carrier's EOB denial of "197" and "930" is not supported.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   The Division conversion factor for 2011 is $54.54.

   The services were rendered Dallas County.

   The MAR for CPT code 72141 in Dallas County is $753.37 (WC Conv 54.54/Medicare Conversion 33.9764 X $469.32 participating amount. The respondent paid $0.00. The difference between the MAR and amount paid is $753.37. The requestor is seeking $687.92; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 687.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $687.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/28/2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.